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Short Communication

Drug of Choice Trends in a Family Treatment Court

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Abstract

Family Treatment Courts (FTCs) are courts that were created to therapeutically deal with parents who have a substance abuse problem and are involved with the child welfare system due to having an indicated neglect case. The current research study is phase two replication and extension of research of the same Family Treatment Court study that conducted and examined data for the years 2003 through 2005 (n=186) for an FTC in a moderate size metropolitan city in New York State. The current study examined participants' self-reported data provided upon intake who were involved over the years 2006 through 2013 (n=322) at the same FTC for the variable of drug of choice. This paper focuses on drug of choice trends in an FTC over several years, particularly heroin and opiates as identified drugs of choice. The increase of abuse of opiates and heroin as well as reasons identified for this trend is discussed. Drug of choice is a topic for examination and further study which may explain trends inthe substance abusing society as well as lend to policy changes and practice and research implications. More research is warranted in this area to formally identify and analyze trends for drugs of choice of substance abusers in the general population as well as in FTCs.

ABBREVIATIONS

FTC: Family Treatment Court

INTRODUCTION

Family Treatment Court

Family Treatment Courts (FTC) are programs that were created to therapeutically deal with parents who have a substance abuse problem and are involved with the child welfare system due to having an indicated neglect case [1]. Many of such children who have been neglected are removed from parental care and placed in foster care while their substance abusing parent is a participant in FTC. The mission of the Family Treatment Court is to provide safe, permanent, fit homes for children in the least amount of time possible while guiding their parents to recovery from their substance abuse addiction. The development of FTCs are one avenue in which the health and human service professions can provide education, training, and support such that families may learn about and overcome struggles regarding neglect and substance abuse while they are monitored by the child welfare and court system [2]. The number of such therapeutic courts has increased 40% from 2005 to 2010, where in 2010 there were 2,459 drug courts in the U.S [3].

Drug of Choice

Drug of choice reflects a participant's substance use, and is defined by indicating which drug (including alcohol) is the primary drug that the participant believes is the cause of his or her problem [2]. The drug of choice for substance abusers is of particular importance because type of drugs used are important factors related to treatment retention and outcome. Although treatment retention and outcomes are not the focus of this paper, it is essential to reflect the importance of the topic of drug of choice. Drug of choice has been shown to have an impact on participants' outcomes in FTC programs [4,2]. Some studies have found significant differences insubstance abuse treatment success outcomes for clients based on type of drug used [5]. Specifically, in drug courts, some studies have found that participants indicated that those who identified their drugs of choice to be a drug more commonly known to cause an intense addiction [6] such as heroin or cocaine, were less likely to complete the drug court program [7,8]. Although some studies claim no relationship between participants' identified drug of choice and successful program completion [9], a majority of research generally supports that drug of choice has contributed to less of a likelihood of successfully completing substance abuse drug treatment court programs [10]. Regarding CPS outcomes, child placement outcomes seemed to be affected by the primary drug of the parent.

Parents whose primary drug of choice was methamphetamine, cocaine/crack or marijuana had the highest rates of reunification with their children at 12 months compared to parents whose drug of choice was heroin or alcohol. At 18 and 24 months, heroin users still had a poor reunification rate, and those whose primary drug of choice was marijuana had the highest rates of reunification; these results were not reported as statistically

significant [4]. However, the issue becomes a focus given the potential impact that drug of choice may have on both treatment as well as child welfare outcomes.

Drug of Choice Trends

Changes in trends regarding drug of choice are identified for the substance abusing population of FTCs today; however, since substance abusing practices vary across the country, demographical information regarding drug of choice will therefore vary as well. Gender seems to be one of the only variables that seems consistent when viewing the demographic of FTC composition, as FTCs are predominantly comprised of females. For example, there may be some uniformity regarding the gender composition for FTCs across the country being predominantly female [2,5]; however, there are varied statistics regarding the drug of choice for various FTCs. One FTC in central Florida (88% female) indicated the breakdown for its participants' drug of choice. Although participants could indicate more than one drug of choice, there was a large majority that identified cocaine (n=131, 70.8%) as the primary drug of choice, followed by alcohol (n=90, 48.6%), marijuana (n=90, 48.6%), opiates (n= 12, 6.5%), and heroin (n= 1, 0.5%) as the drug of choice [5]. Conversely, an evaluation of an FTC in King County in Washington State, considered data collected in 2010 (n=76; 83% female) for FTC participants between the years 2005 and 2009, and indicated that cocaine and heroin (n=12, 15.8%) are equally the first drug of choice; followed by 14.5% identifying alcohol (n=11), 13.2% identifying methamphetamine (n=10) as their first drug of choice. Both marijuana as well as opiates and other synthetics were not indicated largely as drug of choice (n=2, 2.6% for both drug categories) [11,12,13]. Furthermore, an initial phase of an evaluation of an FTC in a moderate sized cityin New York State (79.6% female) found the breakdown of drug of choice to be marijuana (n=36, 27.7%), followed by alcohol (n=34, 26.2%) and crack (n=29, 22.3%) [2] although research regarding family treatment court is steadily increasing, there is little knowledge of any trends regarding drug of choice that have been assessed towards a collective understanding nationally. This is evidenced by the disparity for drug of choice when merely comparing just three FTCs from very different regions around the United States.

Increase in Abuse of Opiates and Heroin and Reasons for the Trend

The increase in heroin and opiate abuse has begun to be seen in much of the substance abusing society today. Many studies have demonstrated the increased accessibility, prevalence and abuse of opiates both nationally [14,15] and internationally including Europe [16,17], and Canada [18,19]. Opiate overdose is a serious global issue effecting all areas from wellness, social aspects and economic realms of society [20] and has therefore become a major public health problem [21]. The World Drug Report [22] indicates that the global prevalence of the use of opiates is 0.7 percent of the world's adult population, which is approximately 32.4 million users; in North America, the prevalence of opiate use is 3.8 percent which is considered high relative to the global average [22]. United States Substance Abuse and Mental Health Services Administration (SAMHSA)(23) reports that there were an estimated 2.1 million people in the United States who had substance abuse diagnoses due to abuse of opiate pain relievers, and that 467,000 are addicted to heroin. Heroin abusers using the substance for the first time have climbed from 90,000 to 156,000, an almost 60 percent increase over the last ten years in new heroin users annually [23]. The quantity of heroin-related deaths has increased from 5,925 in 2012 to 8,257 in 2013, which is the highest level it has reached in ten years and continues to increase in the United States [22]. The Centers for Disease Control and Prevention has called the incidences of overdose of opiate pain relievers an epidemic that is increasing in severity, and that the struggle is linked to differences in opiate pain reliever prescribing [24].

In prior years, heroin and opiates were not largely accessible, reflecting the status of abuse of both of these substances being somewhat minimally demonstrated compared to the other substances such as marijuana and alcohol. While alcohol seems more easily accessible, and marijuana is approaching legalization in many areas and there may be the loosening of the reins on accessibility of the substance, combined with the potential lack of a sufficient high from abusing marijuana, abuse of other substances are increasing as drugs of choice, namely heroin and other opiates as is depicted here. In the last several years, pain management has begun to surge medically, with opiates therefore being the response in prescriptions for pain. Consequently, there has been the concerning effect of abuse and addiction to opiates, and it may likely be the case that physicians did not fully understand the addictive quality of opiates when prescribing. Some patients may have become addicted from having been prescribed opiates for pain; however, many have accessed such drugs in various ways from buying them on the street to stealing such from family medicine cabinets, often seen by youth. It is important to clarify; people who are prescribed opiates are not necessarily abusing their own prescription drugs.

The trend shifted again yielding the surge in heroin to balance opiate abuse due to the astronomical cost of opiates when compared to the lesser cost of an even larger supply of heroin, as well as the changes in the design of OxyContin, which is one of the main prescription opiates that are misused [22], coupled with the institution of stronger legislation that has puts controls on how opiates are dispensed by physicians making it more challenging to access. Heroin is filling the gap and substituting for opiates, as it produces a similar high for significantly less cost. It is essentially the same drug in that both are metabolized into morphine and attach to the same pain receptors, thus creating the desired effect. The fact that heroin is often more potent than prescription opiates also contributes to it being a desirable alternative for users.

Years of changes in the substance abuse usage of participants in FTCs and for the substance abusing society overall reveal drug of choice trends that are relevant to examine towards learning the behaviors of the substance abusing population as well as how they influence research, practice and policy today. This research seeks to investigate whether there has been a significant change in the drug of choice over several years in a FTC in a moderate sized metropolitan city in New York State, with particular focus on examining the increase in heroin and other opiates that have been observed.

MATERIALS AND METHODS

Data were abstracted from the court records of the FTC database on premises; data consisted of self-reported information from the intake screenings conducted by the FTC for all individuals referred to the FTC program. The record data were abstracted for all individuals referred to the FTC program during the years 2006 through 2013, which was a continuation years later from a prior study which assessed the intake data from participants referred to this FTC between 2003 and 2005. The current research study is phase two replication and extension of research of the same Family Treatment Court study that was conducted and examined data for the years 2003-2005 (n=186) for a northeastern FTC in a moderate size metropolitan city in New York State [2]. The current study, therefore, examined participants' self-reported data provided upon intake who were involved over the years 2006 through 2013 (n=322) at the same FTC for the variable of drug of choice.

Regarding the variable drug of choice, only one drug could be selected; it was self-reported at the intake assessment by the participant. The drugs of choice that were offered as categories to offenders upon intake are as follows: crack; cocaine; marijuana; heroin; opiates; prescription drugs; alcohol. Due to the small cell size for prescription drugs, it was dropped from analysis. Modification of this variable therefore resulted in the definition of drug of choice as crack; cocaine; marijuana; heroin; opiates; alcohol [2]. The FTC data regarding the drug of choice for the same FTC in 2008 was collected in an identical manner for the current study; variable definitions remained the same as well.

RESULTS

Initial Phase One Vs Current Phase Two of FTC Study

The initial phase one of the evaluation of this FTC in a moderate sized city in New York State [2] examined data collected during intakes from 2003-2006 and found the breakdown of the top three drugs of choice to be marijuana (n=36, 27.7%), alcohol (n=34, 26.2%) and crack (n=29, 22.3%). Some participants also identified their drug of choice as cocaine (n=16, 12.3%), heroin (n=11, 8.5%), opiates (n=4, 3.1%) (Table 2). Use of prescription drugs was minimal and was removed from analysis for both phases of this study. Gender composition for the phase one study included 79.6% females (n=148). The gender composition remained similar to phase one of the prior FTC research study where females currently comprised 83.5% of the population (Table 1).

In the current phase two of the FTC study, the breakdown of drug of choice indicated that the top reported drug of choice was alcohol (n=42, 22.6%), followed closely by marijuana (n=40, 21.5%). Crack (n=32, 17.2%) and cocaine (n=26, 14%) were the third and fourth highest drugs of choice reported respectively, as they also were in the prior study. Heroin (n=24, 12.9%) was the next identified drug of choice in the current study, followed by opiates (n=22, 11.8%) (Table 2).

Drug of choice for the current phase two studies was compared to drug of choice identified by participants from the 2008 phase one research study within the same FTC. A Pearson's chi-square test of independence was performed to examine the relationship between the two different study phases of participants, past and present, (independent variable) and the drug of choice used by participants (dependent variable). The relationship between study phase and drug of choice was statistically significant $x^2(1) = 11.302$, $p = 0.046$.

DISCUSSION

Statistically significant changes in the trends of drug of choice from phase one to the current phase two of the FTC study have been demonstrated for this FTC population. Although both marijuana and alcohol have been the leading two drugs of choice for both studies, marijuana was the leading drug of choice in phase one of the study for data from 2003 through 2005, and alcohol is currently only marginally the leading drug of choice. It is important to note that aside from the reverse order of the leading two drugs of choice described here from marijuana to alcohol from study phase one to study phase two, the further order for preferences of drug of choice for both studies remained the same, namely, crack, cocaine, heroin, and opiates. The quantities of

Table 1: Gender / Sex.

FTC PHASE ONE STUDY (data from 2003-2005) (Cannavo, 2008)	n	%	FTC PHASE TWO STUDY (data from 2006-2013)	n	%
Male	38	20.4%	Male	53	16.5%
Female	148	79.6%	Female	269	83.5%

Table 2: Drug of Choice.

FTC PHASE ONE STUDY (data from 2003-05) (Cannavo, 2008)	n	%	FTC PHASE TWO STUDY (data from 2006-2013)	n	%
Crack	29	22.3%	Crack	32	17.2%
Cocaine	16	12.3%	Cocaine	26	14%
Marijuana	36	27.7%	Marijuana	40	21.5%
Heroin	11	8.5%	Heroin	24	12.9%
Opiates	4	3.1%	Opiates	22	11.8%
Alcohol	34	26.2%	Alcohol	42	22.6%
Total	130	100%	Total	186	100%

those who abused certain drugs have increased, such as alcohol and crack; however, the overall percentages of the samples for alcohol and crack have declined from phase one to phase two. It is important to note that the percentage identifying heroin and opiates as drug of choice increased. Specifically, heroin increased from 8.5% (n=11) to 12.9% (n=24), and opiates increased from 3.1% (n=4) to 11.8% (n=22). However, the percentage identifying the leading two drugs of choice during phase two for this FTC declined, where marijuana decreased from 27.7% (n=36) to 21.5% (n=40), and alcohol decreased from 26.2% (n=34) to 22.6% (n=42).

It is important to consider a trend as evidenced by the statistical significance found when comparing the phases of study with drug of choice that suggests a rise in abuse of heroin and opiates for this FTC that was not reflected in the earlier phase one study. The increase in heroin and opiates has contributed to the current societal issues and reactive responses from practice and legislation. There are the negative effects that society recognizes and is responding to as a result in the surge of heroin abuse. There has been the institution of training and dissemination of Naloxone, marketed under the trade name of Narcan, a medication used to combat the effects of opioid and particularly an overdose. The race to train and ensure usage of Narcan demonstrates society being reactive to the concerning status of heroin abuse. While legislation, practice and education should ideally be a preventive focus, it is difficult to do that if the substance abuse treatment realm as well as legislators does not always have knowledge of what they need to focus on preventing. Addicts have shown themselves to be very clever experts at enhancing and changing their drugs, seeming to stay just ahead of practice and legislation. The reality is that often practice and particularly legislation have been reactive once society as a whole starts to identify the consequences of new changes in drug uses patterns. With greater lines of communication among research, practice, and legislators, it would be ideal, more economical, therapeutic and ultimately life-saving if there could be a focus on anticipating future possible trends. This concept is raised particularly in a generation when there may seem to be loose limits, and professionals and authorities involved need to think creatively. The legislation that took place to increase restrictions on methods for prescribing by physicians is one aspect that has been important. Finally, as mentioned, drug of choice may possibly have an effect on child welfare outcomes as seen through rates of reunification. More research should be conducted in this area so as to increase awareness of those participants who may be more or less likely to reunify with their children based on their drug of choice. Understanding these child welfare outcomes coupled with the participants' identified drug of choice upon FTC treatment entry may allow substance treatment programs to adjust their programming when participants enroll whose primary drug of choice may be a substance that lends to a less likelihood of reunification according to research. In sum, the examination of certain existing trends for drug of choice may lend to enhanced substance abuse treatment and positive child welfare outcomes, necessary legislation, and is a basis for future study.

There are a few limitations in this study. This study draws its sample from a single FTC in New York State. Therefore, generalize ability is limited; however, this study should be able to be replicated in FTCs nationally to lend further examination. In addition, smaller sample size, particularly of some of cells for analysis of the drug of choice, contributes to limitations. It should be noted, however, that cell sizes increased over time for analysis in phase two as a result of the growth of the FTC program in general as well as due to increase in use of certain drugs by participants.

CONCLUSION

With the rise over the years in abuse of both opiates and heroin, as depicted in the current FTC's study yet seen as an issue that has been illuminated nationally and internationally, more research is warranted in this area to formally identify and analyze trends for drug of choice of substance abusers in the general population as well as in FTCs. This study also is yet another reminder of the need to better bridge research and practice. Practitioners also have the responsibility of continual education on current research trends to enhance their knowledge and understand of the most recently developed treatment modalities. Utilization of this knowledge in a timely manner may serve to facilitate a faster response to changes in substance abuse trends and may positively affect child welfare outcomes. Finally, legislative changes need to continue to be implemented that are preventive instead of reactive overall to substance abuse trends, as trends based on phenomena and clinical dynamics of the substance abusing society may possibly be able to be predicted. We may not know its effectiveness if we have successfully prevented a new avenue to drug abuse.

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